DOCUMENT RESUME

ED 269 704 CG 019 091

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TITLE Going Home: The Derailment of Nursing Home Residents.
PUB DATE Nov 85
NOTE 23p.; Paper presented at the Annual Meeting of the American Public Health Association (113th, Washington, DC, November 17-21, 1985). For related document, see CG 019 092. Best copy available.
PUB TYPE Reports - Research/Technical (143) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Daily Living Skills; *Deinstitutionalization (of Disabled); Family Role; Individual Characteristics; *Institutional Environment; Institutionalized Persons; *Nursing Homes; *Older Adults; Physical Health; *Prognostic Tests; Well Being

ABSTRACT

A nursing home has three discharge tracks, determined at admission and reviewed periodically along with treatment plans. Advised by the admitting physicians, the nursing home social worker assesses each resident's discharge prognosis: (1) a discharge plan is in effect; (2) discharge is problematic; or (3) no discharge is planned. A substantial amount of the literature in the field portrays the nursing home experience as iatrogenic. A study was undertaken to determine the extent to which one nursing home's residents who were admitted with plans for discharge did not return home and to examine the resons for those patients' derailment. A 160-bed Rhode Island nursing home's case records for 1978-84 were examined. The results revealed that, of 419 residents, 79 were expected to return to the community. Only 13 of those 79 did not return home. Content analysis of those 13 residents' histories showed that two chose to remain in the nursing home, four had families who declined to fill caregiver roles, and two quickly deteriorated. Even the histories of the five who generally lost the ability to function independently did not suggest that institutional life was to blame. Their initial discharge plans may have been unduly optimistic. This research suggests that nursing home life does not prove iatrogenic for persons admitted with a positive prognosis. A four-page list of references concludes the document. (Author/NB)

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GOING HOME: THE DERAILMENT OF NURSING HOME RESIDENTS

CG 019091

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GOING HOME: THE DERAILMENT OF NURSING HOME RESIDENTS

Advised by the admitting physician, the nursing home social worker assesses each resident's discharge prognosis: a discharge plan is in effect; discharge is problematic; or no discharge is planned. This research examined one nursing home's case records for 1978-84 to note 1) the extent to which residents admitted with plans for discharge did not return home, and 2) reasons for those patients' derailment. A substantial literature portrays the nursing home experience as iatrogenic. The results of this research did not support that notion of iatrogensis. Of 419 residents, 79 were expected to return to the community. Only 16% of those 79 did not. Content analysis of those residents' histories, moreover, showed that 2 chose to remain, 4 had families who declined to fill caregiver roles, and 2 quickly deteriorated. Even the histories of the five who generally lost the ability to function independently did not suggest institutional life was to blame. Their initial discharge plans may have been unduly optimistic. In conclusion, this research suggests that nursing home life does not prove "iatrogenic" for people admitted with a positive prognosis.

A nursing home has three discharge tracks, determined at admission and reviewed periodically along with treatment plans. Advised by the admitting physician, the nursing home social worker labels the new resident's prognosis for discharge: a discharge plan is in progress, is uncertain at this time, or is not in progress. Most states, mandating discharge plans for Medicaid recipients, regularly review the appropriateness of those plans. On the "discharge plan in progress" track are residents expected to go home: "This is considered a temporary placement." Such residents entered the nursing home for intensive physical therapy (after a hip replacement, for instance) or for a short convalescence. The "no plan in progress" track predicts the placement as permanent, either because the resident has no suitable home in the community or because the resident is expected to die shortly. The judgment that the nursing home is more suitable than the resident's home weighs diverse factors: the nursing needs of the resident, the physical layout of the community home, the availability of family and community agencies, the resident's desires. "Home" is partly a matter of personal definition: for many residents, the nursing home offers a more congenial place than their community niche (Powers,1983). Still other residents have an uncertain prognosis. Their discharge plan is conditional: if the resident recovers sufficiently, if community agencies will cooperate, if the family can find suitable housing. All residents do not remain on their intake tracks. Some, expected to return home, will remain within the nursing home. Admitted with a discharge plan in progress, these residents do not progress as anticipated. This research seeks to examine the phenomenon of "derailed" residents; that is, residents who, in spite of a "discharge plan in progress" at admission, do not go home. These residents' histories offer a test of the general notion of nursing home iatrogenesis.

Popular and professional literature portray the nursing home experience as iatrogenic. As an institution, the nursing home reduces the person to the status of patient. The indivdiual who was parent, worker, spouse becomes "the case in Room 103" (Kahana & Coe,1969). Patients, by definition, make few decisions concerning their lives (Bennett & Nahemow,1965; Mercer & Kane,1979; Withers-Borth et al,1982). The nursing home establishes a routine; and although residents may make minor decisions (chicken or fish for lunch), in most instances residents have little say in the timing of meals, the timing of baths, the choice of companions, the kinds of recreation (Bennett,1980; Gubrium,1975; Tulloch,1975). As residents lose control over daily decisions, so too they may lose their general competence to function outside the nursing home. Some residents enter with diminished control, especially if relatives or physicians have made the decision to enter a nursing home for the resident. Many residents, however, participate in both the decision to enter a nursing home and the choice of home (Smallegan, 1981). For these residents the loss of autonomy begins after admission. As custodial institutions, moreover, nursing homes may neglect the intensive therapy necessary for an individual to leave the home. Notwithstanding treatment plans that include speech therapy, occupational therapy, and physical therapy, many homes' offerings fall short of written descriptions (Hochbaum & Galkin, 1982). Finally, the statistical fact that nursing home "long-stayers" rarely return to the community heightens the notion of institutionally-induced deterioration (Kane et al,1983; Keeler et al, 1981; Liu & Manton,1984; Van Nostrand,1981).

Staff contribute to the iatrogenesis. Trained to perform instrumental tasks on, for, or with residents, staff may regard their charges as "objects of bed and body care" (Gubrium,1975). Staff intent on bed and body routines may neglect to offer psychosocial support (Baker,1974; Handschu,1973). Indeed, one experiment that measured resident functioning when specific nurses

engaged in general conversation not necessary for care found that resident functioning improved (Weiss,1969). Another study found housekeepers more important sources of emotional support than nursing staff (Henderson,1981). If aloof staff depersonalize residents, then overzealous staff eager to push wheelchairs, button clothes, and comb hair may promote an "induced dependence" in residents , whose skills will decline in proportion to staff attention (Avorn & Langer, 1982; Baltes et al,1983; Barton et al,1980; Langer & Benevento,1978; Lester & Baltes,1978; Mikulic,1971). Overly maternal staff who see their charges as children may encourage infantile, incompetent self-images and behavior (Bennett, 1963; Gresham, 1976). Some staff may abuse patients (Stannard,1973).

Nursing homes, moreover, contain confused residents; and proximity to confused residents may depress some individuals (Witzius et al,1981). Within a nursing home the competent resident is not necessarily at an advantage (Posner, 1974). Similarly, the reality of impending death may cast a pall over the nursing home ambiance (Marshall,1975).

Nursing home residents may even suffer "clinical" iatrogenesis. Residents not forced to walk may become bedridden. Bedridden residents may develop bedsores. Poor hygiene in a congregate setting may contribute to the spread of viral and bacterial infections (Sherman et al,1980). Untrained staff may administer medications inappropriately or neglect correct procedures for medical crises (Center for Disease Control, 1984).

The literature on the effects of institutionalization suggests an inevitable iatrogenesis. Induced dependence, loss of autonomy, clinical mistakes, the status of inmate, poor hygiene - all paint a bleak picture of the nursing home. Indeed, the combination of an "iatrogenic" institution and ill, elderly residents would seem sufficient to explain the fact that many residents, particularly long-term ones, rarely leave.

An explanation that focuses not on the physical status of the

resident, but on the resident's community "home," however, is equally feasible. The patient's community home may change during his nursing home stay. When the admitting physician assesses the likelihood of "discharge to the community," the physician assesses not only the individual's functional ability, but also the demands of that community. When "home" is a solitary third-floor apartment, the person must be more mobile, more alert, more independent, than when "home" is a bedroom in a child's ranch-style house. Similarly, the "family" attached to the resident's "home" bears consideration. A resident may more easily return to a healthy spouse than to an invalided one. In determining the requisites of returning "home," the physical structure, the availability of helpers, the proximity to social services must be weighed. Not surprisingly, discharge "home" to rural areas is more difficult than to urban ones (Supiano & Peacock,1981). During the nursing home stay, the "home" of the resident may change: a family may move or may relinquish a parent's apartment. Similarly, a spouse may die, be hospitalized, or enter a nursing home. If the "home" of the resident changes, then the resident may be trapped within the nursing home. The entrapment, though, does not result from physical deterioration or the general effects of prolonged institutionalization, but from the fact that the patient's "home" - one crucial nexus of the discharge plan - has changed.

Caregivers may withdraw from that role. In analyzing entrance into a nursing home, researchers have pointed out that the willingness of the family to care for the elderly person is central (Brody et al,1978; Ikegami, 1982). Willlingness to care for a relative does not necessarily correlate with that relative's functioning: hospital social workers marvel at the range of families "unable to meet patient needs," as well as the range of patient disabilities that families find supportable. Some families will care for an incontinent confused bedridden patient, while other families

will demand continence and lucidity, as well as the ability to ambulate. In deciding whether or not they can meet their relative's needs, the family considers affection, financial resources, the physical structure, and other obligations. Once a relative has lived in a nursing home, the family's calculations may change. Although initially families may experience guilt, they may soon relish the reprieve from constant caregiving. Indeed, families may continue to give their institutionalized relatives expressive, emotional support, while nursing homes provide instrumental services (Brody et al,1978; Rubin & Shuttlesworth,1983).

Finally, many residents participate in the decision to enter a nursing home. Weighing life in the community against life in a nursing home, incoming residents choose the latter. Notwithstanding the grim popular image of nursing homes (Coburn,1977), the muckraking exposes (Moss & Halamandaris,1977), and the profusion of research on the horrors of "institutions," a person may rationally choose to live in a nursing home. It offers regular if unimaginative meals, safety from muggers and burglars, companionship, and help with daily activities. Residents who had lived alone may prefer the nursing home - even if they could function sufficiently independently within the community. Similarly, residents who planned to return home may change their minds. They may come to value the omnipresent staff, the social ambiance, the safety, the lack of responsibility, even the recognition that they are no longer a burden on family caregivers. Crystal (1982) noted that contemporary elderly people prefer not to be dependent upon family. Life within the nursing home frees the resident from his/her own guilt. Residents subject to abuse and/or neglect at "home" may find the nursing home a welcome haven.

Method of Analysis

The case histories of 419 residents admitted to a proprietary 160-bed Rhode Island nursing home detail each person's discharge plan at

admission and eventual discharge status. The sample included all residents discharged between 1978 and 1984, the first six years of the home's operation. The home offers both Skilled Nursing and Intermediate-level care. The home is not atypical. While sparkling corridors and an antiseptic aroma testify to a diligent staff, this home, like many others, is a proprietary institution with no formal links to a university or medical center, no staff specifically trained in gerontology, no model resocialization programs for residents. Since state regulations require nursing homes to review discharge plans periodically, with reasons for changes, it was possible to trace changes in prognosis. Content analysis was done of the case histories for those residents whose initial discharge predicted that they would go home, yet whose discharge prognosis changed during their nursing home stay. The research asked why those patients did not go home, why in effect they were "derailed."

Three themes were considered:

1. Change in patient status
    a. a change in physical status, noted by a new or revised medical diagnosis; e.g., a stroke occurring within the nursing home, the discovery of a tumor, a heart attack. Admittedly, physical status of the resident will depend upon nursing care, and in specific cases the distinction between clinical iatrogenesis and physical deterioration independent of the effects of the nursing home may blur.

    b. changes in overall functioning, not directly linked to a specific medical incident. When nursing notes described the patient as "weak," "apathetic," "had no appetite," this was considered a loss of ability to function. Again, the demarcation between a distinct physical change and overall deterioration may be spurious, especially since one may precipitate the other. A patient may be deteriorating, not because of institutional iatrogenesis, but because of an undetected change in medical condition. Indeed, a precise delineation between exogenous changes in physical functioning and changes induced by prolonged institutionalization may not be possible. This research, however, seeks to separate changes in family status from changes in patient status.

2. Changes in Family Status, delineated as:

a. death of caregiver (spouse, sibling, child, extended family)

b. inability of caregiver to fill role

c. change in residence of family

3. Patient chooses to remain in nursing home.

Residents were given scores on each of the above dimensions. One resident may score on several items; that is, during a resident's stay, a spouse may die and the resident may suffer a stroke.

Results

Of the 419 residents discharged between June 1978 and July 1984, the first six years of the institution's operation, the discharge prognosis proved a powerful predictor of discharge status. Most people admitted to the nursing home with a favorable prognosis ("expected to return to the community") did in fact leave, while most people admitted with an unfavorable prognosis either died at this nursing home or transferred to another. Table 1 summarizes discharge status by admission prognosis.

Only 13 of 79 residents were truly "derailed;" that is, were admitted with favorable prognoses, yet did not return home. The literature on the deleterious effects of institutionalization portrays the nursing home as an iatrogenic placement where residents inevitably deteriorate. Residents may in fact deteriorate within a nursing home, yet those residents' deteriorating status is not necessarily due to their nursing home stay. If nursing home placements were inevitably iatrogenic, we would expect to find more residents who, contrary to expectations of discharge home, remained within the nursing home.

Table 1. Discharge Status* by Admission Prognosis

	Permanent Placement N=297	Uncertain N=39	Temporary Placement N=79
Died	61.6%(183)	38.4%(15)	6.3%(5)
Transferred	29.2%(85)	18.0%(7)	10.1%(8)
Returned to:			
Own Home Alone	2.7%(8)	35.9%(14)	45.6%(36)
Own Home with Relatives	2.4%(7)	2.6%(1)	19.0%(15)
Child's Home	2.7%(8)	5.1%(2)	17.7%(14)
Relative's Home	.7%(2)	---	1.3%(1)
Hospital, then Unknown	1.7%(5)	---	-----

* Discharge was coded according to final status, regardless of hospitalization. People who died or transferred may have been initially admitted to a hospital.

If the small number of "derailed" residents raises questions about the emphasis placed on the deleterious impact of nursing home residence, content analysis of case histories raises additional questions. Each resident's history was reviewed to discern what happened between admission and the time the social worker revised the discharge plan. Table 2 summarizes the results.

Two residents chose to remain in the nursing home. One, a never-married 68 year-old man, had lived alone in a third floor apartment. A niece lived on the first floor. The admitting physician advised that the patient could go home after six months. Even though the apartment was still paid for, the patient decided he did not want to return. He enjoyed the activity and security of the nursing home. An 82 year-old widower, who also had lived alone, had children who maintained his apartment. At the end of two months this patient chose not to return home, but to transfer to another nursing home, where he had once been a patient. Weighing his community home against an institutional one, the resident chose the institution.

Four residents could have gone home if caregivers had not reneged. A 65 year-old widower had lived with his sister. His discharge plan specified that he would return to his sister's apartment, but after two months his sister explained she was too ill to care for him. Also, the sister moved into a one-bedroom apartment which, the sister explained, was too small for two people. Eventually, after twenty-eight months at this nursing home, the patient transferred to a home for veterans. An 85 year-old widow who had lived in an apartment upstairs from her son was supposed to return to live directly with a family member. Eight months after admission, the patient reportedly called her daughter-in-law to ask to live with her. The daughter-in-law refused. After two past nursing home stays the patient had returned to the care of the daughter-in-law.

Table 2. Reasons for Change in Discharge Prognosis

	Number of Residents
1. Change in Patient Status	
a. physical status	2
b. general functioning	5
2. Change in Family Status	
a. inability of caregiver sibling to fill role	1
b. inability of caregiver child to fill role	2
c. inability of extended family caregiver to fill role	1
3. Patient Chooses to Remain, Given Option to Leave	2

but this time the daughter-in-law refused. Two months later the patient was admitted to the hospital. She returned to a different nursing home. The discharge plan for an 81 year-old widow called for her to return to her daughter's home. Five months after admission, the social worker case notes reported that neither the son nor the daughter wanted her to live with them. Three months later the woman died. Finally, the nursing home expected a 72 year-old never-married woman who had lived alone to return to her own apartment. Community agencies, assisted and supervised by extended family, would help the woman. Since the patient was on a "discharge" track, staff expressly encouraged her to practice walking, bathing, and dressing, so that she could return home. After seven days, the family complained that the staff made the patient do too much. On the family's insistence, the patient transferred to another nursing home. She did not return to the community.

Even residents who faced no family obstacles to returning home did not necessarily deteriorate as a result of their nursing home stay. Two residents quickly declined physically after admission. Edith Black, an 82 year-old widow with no living children and one sibling, had lived alone. She was admitted with a diagnosis of "bronchopneumonia and generalized weakness." Five months previously she had been hospitalized for anemia, yet discharged home alone. This time, however, the hospital discharged her to a nursing home for convalescence. The discharge plan specified that the social worker would get her SSI and homemaker services, so that she would return to her own apartment better able to function. After two months, she was hospitalized and died. Sally Miller, a 71 year-old widow living alone, but with children nearby, was admitted with an optimistic assessment. Surprisingly to staff, her functional ability declined. Three months after admission, when a tumor was diagnosed, her discharge prognosis changed to "a permanent placement." One year later she died.

Admittedly, both women deteriorated after placement, but the nursing home does not appear culpable.

Five other residents' functional ability deteriorated, yet again their histories exonerate the nursing home. Indeed, one resident improved during his tenure. Adam Bennett, a 62 year-old married laborer, admitted from his own home, had suffered a stroke. The discharge plan specified that staff would work with him until he could enter a nearby Rehabilitation Unit. From rehabilitation, the social worker expected him to return home. After eight months in the nursing home, he had improved sufficiently to enter the Rehabilitation Unit, yet he did not progress sufficiently in Rehabilitation to return to the community. From the Rehabilitation Unit he was discharged to another nursing home.

In retrospect, the favorable discharge prognoses of four derailed residents seem unduly sanguine. One 92 year-old widow, living alone, was expected to return to her solitary apartment. Two weeks earlier, she had been hospitalized, yet discharged to her home. After a subsequent hospitalization for electrolyte imbalance and a urinary tract infection, she entered this nursing home for convalescence. She stayed two months, was hospitalized, discharged to another nursing home, then transferred back to this home. Six days after readmission she died. Another resident was admitted with a more Panglossian prognosis. A 28 year-old never-married woman, diagnosed as schizophrenic, had no family. After "de-institutionalization," she had been living in a group home, where she became violent and injured herself. She was hospitalized in a psychiatric facility, then discharged to this nursing home for convalescence. The social worker specified "discharge plan in progress," expecting to discharge her to the group home. Also, the social worker felt that regardless of the woman's ability to function in a group home, a geriatric long-term care facility was not appropriate. Twenty-two days after

admission, the nursing director noted that the patient was having difficulty controlling her voices. One day later the woman was re-hospitalized, then later transferred to the state institution. Staff believed two factors stymied this patient's recovery. First, she had been a patient of one jurisdiction's mental health facility, then transferred to a nursing home in a different mental health cachement area. Since responsibility for this patient shifted with the move, she enjoyed no continuity of relationships with former health workers. Although the new jurisdiction's mental health facility agreed to treat the patient, neither the paperwork nor the relationship was in place. Second, the psychiatric hospital had promised support when the nursing home agreed to admit her. The Director of Nurses reported none. Another resident, 76 years old, had transferred to this nursing home to join his wife, a patient here. His diagnoses included diabetes, cancer of the colon, leg edema, alcohol abuse, and cirrhosis of the liver. The couple had no children. The man's discharge plan called for him and his wife to live together in their own apartment, assisted by community agencies. After 48 days, staff complained that he was physically and verbally abusive. He struck his wife twice. He was discharged to the hospital and from there to the state institution. An 81 year-old widow who had lived alone was expected to return home. Staff, though, reported that she did not try to help herself. Notwithstanding the literature on induced dependence, nursing notes reported that she was refusing to assume as much responsibility for self-care as she might. Since this was a "temporary" placement, staff recognized that she needed to practice basic tasks, yet she did not cooperate, in spite of her professed desire to go home. After five months, both patient and family acknowledged this placement as "permanent." Indeed, the patient herself on admission might have seen a return home as impossible - and not necessarily desirable. Four months after the change in discharge plan, she

went to the hospital for three days. Upon readmission, staff noted she was "relieved to be back in her old room." Her functioning continued to decline. Three months after hospitalization, she only fed herself, even though staff still felt she could do more. Three months later, she died. This woman did deteriorate within the nursing home, but nursing notes suggest that staff were trying to reverse that deterioration.

CONCLUSION

Although both the popular and professional literature portray the nursing home as "iatrogenic," that notion may unfairly malign the nursing home experience. Nursing homes are institutions with routines that allow little patient autonomy. Residents are primarily "patients." Staff perform instrumental tasks on, for, or with residents. Some staff, faced with ill patients, may unwittingly promote dependence; other staff may infantilize patients; still other staff may abuse patients. With ill people clustered in one building, residents are susceptible to bacterial and viral infections. Many residents do deteriorate in a nursing home. Within this home, three-quarters of residents either died or transferred to another facility. The admitting physician, however, did not expect most of these people to return home. Of 419 residents discharged in the first six years of this nursing home's operation, 79 entered with favorable prognoses. Eighty-four percent of this group did return to the community. Only 16% were derailed -and case histories do not suggest that the nursing home was to blame. Admittedly, the nursing home experience may be iatrogenic for those with uncertain or negative prognoses. These 79 residents may have escaped comparatively unscathed because they stayed only a short while, because staff treated "temporary" residents differently from "permanent" ones, or because they themselves recognized their role of patient as short-term and hence avoided the "loss of self" endemic to institutional life. These 79 residents, however, do not appear to have suffered as a result of their nursing home stay - a fact that suggests the notion of institutional iatrogenesis merits more scrutiny.

Public policy may justifiably choose to reduce nursing home admissions because people can be treated more humanely at home, because community agencies offer more cost-effective care, because the family

gives more nurturing support, or because elderly people prefer to remain within the community. Policy-makers, however, need not assume that nursing homes inevitably contribute to the deterioration of their elderly residents.

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